		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040956

Facility Name: THE WEALSHIRE

Address: 150 JAMESTOWN LANE (Number) LINCOLNSHIRE (City) 60069 (Zip Code)

County: LAKE

Telephone Number: (847) 883-9000 **Fax #** (847) 883-9029

HFS ID Number: 363952069001

Date of Initial License for Current Owners: 08/15/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SUSAN CORONADO **Telephone Number:** (847) 883-9000

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ARNOLD GOLDBERG
(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	132	Skilled (SNF)	132	48,180	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	12	Sheltered Care (SC)	12	4,380	5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	850	5,423	4,369	10,642	8
9	SNF/PED					9
10	ICF	2,918	14,654		17,572	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,768	20,077	4,369	28,214	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.68%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
DAYCARE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/14/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/14/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 60 and days of care provided _____

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number THE WEALSHIRE # 0040956 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	201,524	21,537		223,061		223,061		223,061			1
2	Food Purchase		205,492		205,492	(10,185)	195,307	(28)	195,279			2
3	Housekeeping	234,139	25,223		259,362		259,362		259,362			3
4	Laundry	34,820	23,507		58,327		58,327		58,327			4
5	Heat and Other Utilities			190,518	190,518		190,518		190,518			5
6	Maintenance	66,211	5,565	120,941	192,717		192,717	25,500	218,217			6
7	Other (specify):*											7
8	**TOTAL General Services**	536,694	281,324	311,459	1,129,477	(10,185)	1,119,292	25,472	1,144,764			8
	B. Health Care and Programs											
9	Medical Director			59,374	59,374		59,374		59,374			9
10	Nursing and Medical Records	2,254,134	96,607	40,722	2,391,463	60,570	2,452,033		2,452,033			10
10a	Therapy	167,350	1,946	6,151	175,447	(60,570)	114,877		114,877			10a
11	Activities	244,057	9,020	7,746	260,823		260,823		260,823			11
12	Social Services	27,750			27,750		27,750		27,750			12
13	CNA Training											13
14	Program Transportation			118	118		118		118			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,693,291	107,573	114,111	2,914,975		2,914,975		2,914,975			16
	C. General Administration											
17	Administrative	60,989		347,900	408,889		408,889		408,889			17
18	Directors Fees											18
19	Professional Services			102,294	102,294		102,294	(21,286)	81,008			19
20	Dues, Fees, Subscriptions & Promotions			107,535	107,535	1,459	108,994	(101,021)	7,973			20
21	Clerical & General Office Expenses	305,919	30,624	74,150	410,693	(1,459)	409,234	(97,190)	312,044			21
22	Employee Benefits & Payroll Taxes			719,775	719,775	10,185	729,960		729,960			22
23	Inservice Training & Education			4,502	4,502		4,502		4,502			23
24	Travel and Seminar			3,447	3,447		3,447		3,447			24
25	Other Admin. Staff Transportation			24,178	24,178		24,178		24,178			25
26	Insurance-Prop.Liab.Malpractice			189	189		189	294,396	294,585			26
27	Other (specify):*											27
28	**TOTAL General Administration**	366,908	30,624	1,383,970	1,781,502	10,185	1,791,687	74,899	1,866,586			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,596,893	419,521	1,809,540	5,825,954		5,825,954	100,371	5,926,325			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number THE WEALSHIRE #0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,997	41,997		41,997	780,479	822,476			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,427	18,427		18,427	1,138,128	1,156,555			32
33	Real Estate Taxes							128,852	128,852			33
34	Rent-Facility & Grounds			1,800,000	1,800,000		1,800,000	(1,800,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							9,265	9,265			36
37	TOTAL Ownership			1,860,424	1,860,424		1,860,424	256,724	2,117,148			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,499	1,499		1,499		1,499			38
39	Ancillary Service Centers		265,553	19,003	284,556		284,556		284,556			39
40	Barber and Beauty Shops			28,482	28,482		28,482		28,482			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,270	72,270		72,270		72,270			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		265,553	121,254	386,807		386,807		386,807			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,596,893	685,074	3,791,218	8,073,185		8,073,185	357,095	8,430,280			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(28)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	300,479	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,078)	21		18
19	Entertainment				19
20	Contributions	(1,790)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,594)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,810)	21		24
25	Fund Raising, Advertising and Promotional	(76,555)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(106,150)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 76,474		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	280,621		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 280,621		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 357,095		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

THE WEALSHIRE

ID# 0040956

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SUPPLIES & INCENTIVES	$ (5,648)	20	1
2	MARKETING SALARIES	(74,992)	21	2
3	MARKETING CONSULTANT	(6,692)	19	3
4				4
5	CHAMBERS OF COMMERCE DUES	(226)	20	5
6				6
7				7
8				8
9				9
10	CREDIT CARD FEES	(18,592)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(106,150)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE WEALSHIRE # 0040956 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(28)	0	0	0	0	0	0	0	0	0	0	(28)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	25,500	0	0	0	0	0	0	0	0	0	25,500	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(28)	25,500	0	0	0	0	0	0	0	0	0	25,472	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,286)	0	0	0	0	0	0	0	0	0	0	(21,286)	19
20	Fees, Subscriptions & Promotions	(101,021)	0	0	0	0	0	0	0	0	0	0	(101,021)	20
21	Clerical & General Office Expenses	(101,670)	4,480	0	0	0	0	0	0	0	0	0	(97,190)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	294,396	0	0	0	0	0	0	0	0	0	294,396	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(223,977)	298,876	0	0	0	0	0	0	0	0	0	74,899	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(224,005)	324,376	0	0	0	0	0	0	0	0	0	100,371	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **THE WEALSHIRE** **# 0040956** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	300,479	480,000	0	0	0	0	0	0	0	0	0	780,479	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	1,138,128	0	0	0	0	0	0	0	0	0	1,138,128	32
33	Real Estate Taxes	0	128,852	0	0	0	0	0	0	0	0	0	128,852	33
34	Rent-Facility & Grounds	0	(1,800,000)	0	0	0	0	0	0	0	0	0	(1,800,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	9,265	0	0	0	0	0	0	0	0	0	9,265	36
37	**TOTAL Ownership**	300,479	(43,755)	0	0	0	0	0	0	0	0	0	256,724	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	76,474	280,621	0	0	0	0	0	0	0	0	0	357,095	45

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ARNOLD GOLDBERG	OWNER	ADMINISTRATIV	99.00	NONE	35	70.00	ALLOC MGM	$ 347,900	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 347,900		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ARNOLD GOLDBERG	99	THE PONDS OF WEALSHIRE	LINCOLNSHIRE	LINCOLNSHIRE PR	LINCOLNSHIRE	BLDG PRTNRSH
THEWEALSHIRE, INC.	01			ALEXANDER BLAK	SKOKIE	MGMT CO

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,800,000	LINCOLNSHIRE PROPERTIES, LP		$	$ (1,800,000)	1
2	V	19	ACCOUNTING FEES		LINCOLNSHIRE PROPERTIES, LP				2
3	V	26	INSURANCE		LINCOLNSHIRE PROPERTIES, LP		294,396	294,396	3
4	V	32	MORTGAGE INTEREST		LINCOLNSHIRE PROPERTIES, LP		1,138,128	1,138,128	4
5	V	21	OFFICE EXPENSES		LINCOLNSHIRE PROPERTIES, LP		4,480	4,480	5
6	V	6	MAINTENANCE		LINCOLNSHIRE PROPERTIES, LP		25,500	25,500	6
7	V	33	REAL ESTATE TAXES		LINCOLNSHIRE PROPERTIES, LP		128,852	128,852	7
8	V	30	BOOK DEPRECIATION		LINCOLNSHIRE PROPERTIES, LP		480,000	480,000	8
9	V	36	LATE FEES		LINCOLNSHIRE PROPERTIES, LP		9,265	9,265	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,800,000			$ 2,080,621	$ * 280,621	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY LINCOLNSHIRE		X	MORTGAGE	$129,285.00	10/31/97	$ 16,000,000	$ 14,097,059	10/31/07	8.1500	$ 1,078,729	1
2	DIAWA FINANCE CORP		X	MORTGAGE LOAN FEES AMORTIZED OVER 10 YEARS			593,987	108,895			59,399	2
3												3
4												4
5												5
	Working Capital											
6	1ST EQUITY LINE OF CREDIT		X	LINE OF CREDIT	DEMAND		250,000			5.7500	18,427	6
7												7
8												8
9	TOTAL Facility Related				$129,285.00		$ 16,843,987	$ 14,205,954			$ 1,156,555	9
	B. Non-Facility Related*											
10	RELATEDPARTY LINCOLNSHIRE PROPERTIES											10
11			X	VEHICLE LOAN				3,559				11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 3,559			$	14
15	TOTALS (line 9+line14)						$ 16,843,987	$ 14,209,513			$ 1,156,555	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NA Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number THE WEALSHIRE # 0040956 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 128,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 128,852	2
3. Under or (over) accrual (line 2 minus line 1).	$ 852	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 128,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 128,852	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	113,126	8
2001	114,629	9
2002	117,858	10
2003	121,564	11
2004	128,852	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE WEALSHIRE COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0040956

CONTACT PERSON REGARDING THIS REPORT Susan Coronado

TELEPHONE (847) 883-9000 FAX #: (847) 478-9287

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-15-200-062	Nursing Home	$ 128,851.62	$ 128,851.62
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 128,851.62	$ 128,851.62

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 20(tax bill which is normally paid during 2005

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,477 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

The Ponds of Wealshire LLC; Assisted Living Sheltered Care, 141 Licensed Beds

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	273,375	1994	$ 970,925	1
2					2
3	TOTALS	273,375		$ 970,925	3

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	LINCOLNSHIRE PROPERTIES:			1995	$ 11,521,031	$ 317,142	20	$ 576,052	$ 258,910	$ 5,976,539	4
5	144										5
6											6
7											7
8											8
	Improvement Type**										
9	LINCOLNSHIRE PROPERTIES:										9
10	MUSIC SYSTEM			1999	33,003	846	20	1,650	804	10,244	10
11	SIDEWALK			1999	4,660	290	20	233	(57)	1,437	11
12	PATIO			2001	5,200	416	20	260	(156)	1,073	12
13	SIDEWALK			2001	2,325	186	20	116	(70)	479	13
14	CARPETING			2002	12,473	2,844	20	624	(2,220)	1,950	14
15	SPRINKLER SYSTEM			2002	6,805	589	20	340	(249)	1,119	15
16	REMODELING			2003	20,650	4,007	20	1,033	(2,975)	2,367	16
17	SIGNAGE			2004	6,000	857	7	857	0	1,143	17
18	REMODELING - WINDOWS PB			2004	9,411	471	15	627	156	1,254	18
19	REMODELING KITCHEN - CC			2004	34,889	4,986	7	4,984	(2)	7,476	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LEASEHOLD IMPROVEMENTS	1995	$ 34,126	$ 875	20	$ 1,706	$ 831	$ 17,388	37
38	LEASEHOLD IMPROVEMENTS	1996	4,059	339	20	203	(136)	1,922	38
39	LEASEHOLD IMPROVEMENTS	1998	3,993	0	20	399	399	2,926	39
40	ALARM SYSTEM	1999	9,183	235	20	459	224	2,881	40
41	SECURITY SYSTEM	1999	4,427	114	20	221	107	1,369	41
42	CABLING/WINDOWS/CABINETS/LUMBER/FIRE SAFETY/ETC	2000	23,775	610	20	1,189	579	6,639	42
43	SIGN	2000	1,611	41	20	81	40	439	43
44	BOILER WORK	2000	871		20	44	44	220	44
45	BEARING & ASSEMBLING	2001	1,136		20	57	57	266	45
46	PUMP W/MOTOR	2001	704		20	35	35	149	46
47	COMPRESSOR	2001	1,797		20	90	90	413	47
48	BOILER WORK	2001	1,722		20	86	86	423	48
49	BOILER WORK	2001	1,008		20	50	50	246	49
50	ROOF REPAIR	2001	500	13	20	25	12	110	50
51	PHONE SYSTEM	2001	1,713	44	20	86	42	423	51
52	BLACKTOP & PATCH	2001	4,799		20	240	240	1,200	52
53	CARPETING	2002	1,158	165	20	58	(107)	229	53
54	EXTERIOR DOORS	2002	9,700	485	20	485		1,506	54
55	BOILER REPAIRS	2002	8,124		20	406	406	1,624	55
56	SPRINKLER SYSTEM	2002	950		20	48	48	192	56
57	BLACKTOP REPAIR	2002	2,799		20	140	140	560	57
58	BOILER REPAIRS	2002	1,077		20	54	54	216	58
59	PUMP & BOILER REPAIRS	2002	3,376		20	169	169	676	59
60	FIRE SAFETY UPGRADES	2003	9,901		20	495	495	1,238	60
61	SEWAGE EJECTORS/DISPOSER/PUMP	2003	12,848	329	20	642	313	1,605	61
62	BORIS BARBARIC-PAINTING	2003	5,950	2,023	5	1,190	(833)	2,975	62
63	TELEPHONE LINES	2003	4,229	108	20	211	103	528	63
64	IRRIGATION SYSTEM BOOSTER PUMP/HEADS	2004	5,530	54	39	54		59	64
65	UPGRADE BOILER CONTROLS	2004	2,109	142	39	142		166	65
66	SIGNAGE	2005	2,788	93	20	93		93	66
67	HANDICAP RAMP	2005	1,700	32	20	32		32	67
68	LANDSCAPE LIGHTING	2005	7,022	59	20	59		59	68
69	CHILLER REPLACEMENT EXCESS	2005	5,000	125	15	125		125	69
70	TOTAL (lines 4 thru 69)		$ 11,836,132	$ 338,520		$ 596,150	$ 257,630	$ 6,053,978	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,806,653	$ 32,042	$ 185,019	$ 152,977	3-20 YR	$ 1,625,546	71
72	Current Year Purchases	26,895	2,294	2,294		5,7,15,20YR	2,294	72
73	Fully Depreciated Assets	126,096					126,096	73
74	LINCOLNSHIRE PROPERTIES	296,029	30,533	36,113	5,580	3-20 YR	183,558	74
75	TOTALS	$ 2,255,673	$ 64,869	$ 223,426	$ 158,557		$ 1,937,494	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		96 DODGE RAM	2001	$ 14,500	$ 1,775	$ 2,900	$ 1,125	5	$ 12,567	76
77										77
78										78
79										79
80	TOTALS			$ 14,500	$ 1,775	$ 2,900	$ 1,125		$ 12,567	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,077,230	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 405,164	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 822,476	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 417,312	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,004,039	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	LINCONSHIRE PROPERTIES	$	$	$	86
87	COMPLETION OF BLDG 1996	58,161	1,491		87
88	LANDSCAPING	43,000	2,541		88
89	BUILDING 1997 SECT 754	4,482,861	107,316		89
90	Auto 2005	38,983	5,485		90
91	TOTALS	$ 4,623,005	$ 116,833	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Lincolnshire Properties - Consolidationg Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1996/1997	144	1997	$ 1,800,000			3
4	Additions							4
5								5
6								6
7	TOTAL		144		$ 1,800,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34. ____
This amount was calculated by dividing the total amount to be amortized ____
by the length of the lease ____.

9. Option to Buy: [ ] YES [X] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	484	hrs	$ 21,791		$ 1,126	$	484	$ 22,917	1
2	Licensed Speech and Language Development Therapist	10a-8	299	hrs	14,307			5,025	299	19,332	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a-8	1394	hrs	47,941			1,946	1,394	49,887	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39-8		# of prescrpts				261,899		261,899	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): Oxygen/Labs/XRAY	39-8						22,656		22,656	13
14	TOTAL				$ 84,039		$ 1,126	$ 291,526	2,177	$ 376,691	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number THE WEALSHIRE **#** 0040956 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (10,678)	$ (10,678)	1
2	Cash-Patient Deposits	3,378	3,378	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	428,143	428,143	3
4	Supply Inventory (priced at cost)	37,594	37,594	4
5	Short-Term Investments			5
6	Prepaid Insurance	304,822	304,822	6
7	Other Prepaid Expenses	1,326	1,326	7
8	Accounts Receivable (owners or related parties)	883,930	883,930	8
9	Other(specify): Employee loand/Mtge escrows	20,727	21,047	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,669,242	$ 1,669,562	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,190,356	13
14	Buildings, at Historical Cost		17,001,379	14
15	Leasehold Improvements, at Historical Cost	123,718	306,810	15
16	Equipment, at Historical Cost	529,733	864,868	16
17	Accumulated Depreciation (book methods)	(438,128)	(8,104,808)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Repl. Reserve /Unamort Loan Fees		147,064	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 215,323	$ 13,405,669	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,884,565	$ 15,075,231	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,119,802	$ 1,141,754	26
27	Officer's Accounts Payable	56,551	56,551	27
28	Accounts Payable-Patient Deposits	3,378	3,378	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	125,318	125,318	30
31	Accrued Taxes Payable (excluding real estate taxes)	46,400	46,400	31
32	Accrued Real Estate Taxes(Sch.IX-B)		128,000	32
33	Accrued Interest Payable		486,430	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Rent Payable/Due To Affiliates	1,247,612	148,233	36
37	Accrued Management Fees	539,005	539,005	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,138,066	$ 2,675,069	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		3,559	39
40	Mortgage Payable		14,097,059	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 14,100,618	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,138,066	$ 16,775,687	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,253,501)	$ (1,700,456)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,884,565	$ 15,075,231	48

***(See instructions.)**

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,311,721)	1
2	Restatements (describe):		2
3	**PRIOR YEAR ADJUSTMENT**	(399,483)	3
4	**RECLASS FROM OFFICER AP TO EQUITY**	1,805,000	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (906,204)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,547,297)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	1,200,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (347,297)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,253,501)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,913,594	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,913,594	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	555,048	6
7	Oxygen	7,473	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 562,521	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	28,635	13
14	Non-Patient Meals	28	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 28,663	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		21,097	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,097	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,525,888	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,119,292	31
32	Health Care	2,914,975	32
33	General Administration	1,791,687	33
	B. Capital Expense		
34	Ownership	1,860,424	34
	C. Ancillary Expense		
35	Special Cost Centers	314,537	35
36	Provider Participation Fee	72,270	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,073,185	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,547,297)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,547,297)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? to complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,154	1,233	$ 62,508	$ 50.70	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,751	30,656	812,813	26.51	3
4	Licensed Practical Nurses	11,328	11,984	283,392	23.65	4
5	CNAs & Orderlies	83,127	89,311	984,743	11.03	5
6	CNA Trainees					6
7	Licensed Therapist	2,046	2,177	84,039	38.60	7
8	Rehab/Therapy Aides	3,714	4,094	61,802	15.10	8
9	Activity Director	1,626	1,715	51,054	29.77	9
10	Activity Assistants	14,082	15,438	193,003	12.50	10
11	Social Service Workers	1,247	1,417	27,750	19.58	11
12	Dietician	911	911	18,662	20.49	12
13	Food Service Supervisor	1,147	1,263	39,058	30.92	13
14	Head Cook	1,533	1,633	26,435	16.19	14
15	Cook Helpers/Assistants	12,533	13,375	117,369	8.78	15
16	Dishwashers					16
17	Maintenance Workers	2,546	2,817	66,211	23.50	17
18	Housekeepers	23,432	25,504	234,139	9.18	18
19	Laundry	3,232	3,661	34,820	9.51	19
20	Administrator	1,468	1,655	60,989	36.85	20
21	Assistant Administrator					21
22	Other Administrative	5,434	6,290	157,026	24.96	22
23	Office Manager					23
24	Clerical	7,622	7,817	73,901	9.45	24
25	Vocational Instruction	925	825	21,509	26.07	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	568	679	23,548	34.68	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	373	489	5,381	11.00	31
32	Other Health Ca Nrse Supervs	2,588	2,901	81,749	28.18	32
33	Other(specify) Marketing	1,960	2,079	74,992	36.07	33
34	TOTAL (lines 1 - 33)	213,347	229,924	$ 3,596,893 *	$ 15.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		59,374	9-3	36
37	Medical Records Consultant		1,316	10-3	37
38	Nurse Consultant		(1,761)	10-3	38
39	Pharmacist Consultant		666	19-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Marketing		6,692	19-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 66,287		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Norma Wilson	Administrator		27,814
Melisa Dominowski	ASST ADMIN		33,175
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,989

B. Administrative - Other

Description	Amount
Management Fees	$ 347,900
TOTAL (agree to Schedule V, line 17, col. 3)	$ 347,900
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wilson	Accounting	$ 1,388
Misc		127
Enloe Pharmacy	Pharmacy Consulting	666
BARBARA CARTER BERGER	Marketing Consultant	6,692
AMEX TBS	Refinancing	12,000
AAOD	BILLING?OPERATING SOFT	6,828
BAKER_MILLER	COST EVALUATION	1,833
ALBERT MILTON	CLERGY - CANTOR	2,450
JACOB FINE	APPRAISAL	5,000
HERBERT S KAMIN	ADMINISTRATOR PSYCH AS	1,124
SEE SUPPORT PG 25	ACCOUNTING	25,979
SEE SUPPORT PG 26	LEGAL	38,208
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 102,295

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 238,385
Unemployment Compensation Insurance	113,338
FICA Taxes	238,226
Employee Health Insurance	109,350
Employee Meals	10,185
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE LIFE INSURANCE	6,393
LAB TESTS	76
EMPLOYEE AWARDS AND APPRECIATION	13,887
LUNCHES, DONUT DAYS ETC.	
401k Employer Contribution	120
TOTAL (agree to Schedule V, line 22, col.8)	$ 729,960

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,393
Advertising: Employee Recruitment	4,026
Health Care Worker Background Check	749
(Indicate # of checks performed 75)	
Dues	568
Misc	1,463
Credit Card Fees	18,592
Marketing & Public Relations	82,203
Less Chamber of Commerce Fees	(226)
Less : Credit Card Fees	(18,592)
Less: Public Relations Expense	(82,203)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,973

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,447
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,447

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12	RELATED PARTY LINCOLNSHIRE PROPERTIES												
13	PAINTING AND REPAIR	2003	30,206	3			5,034	10,069	10,069	5,034			
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 30,206		$	$	$ 5,034	$ 10,069	$ 10,069	$ 5,034	$	$	$

Facility Name & ID Number THE WEALSHIRE # 0040956 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 37,261 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES NO NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 72,270
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 10,185 Has any meal income been offset against related costs? YES Indicate the amount. $ 28

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

STATE OF ILLINOIS
THE WEALSHIRE
ID# 0040956
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	V- COLUMN 5 RECLASSIFICATIONS	Amount	Sch. V Line Reference
1			
2	EMPLOYEE MEALS	(10,185)	2
3	EMPLOYEE MEALS	10,185	22
4			
5	WEB SITE SUPPORT	(1,459)	21
6	WEB SITE SUPPORT	1,459	20
7			
8	INSERVICE TRAINER	(21,510)	19
9	INSERVICE TRAINER	21,510	10
10			
11	INSERVICE TRAINER	(39,060)	10
12	INSERVICE TRAINER	39,060	12
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32	**Total**	0	

STATE OF ILLINOIS
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XIX-C. Professional Services

Vendor/Payee	Type	Amount
ACCOUNTING:		
LERMAN BOUDART & ASSOC	ACCOUNTING	14,645
DAVID HAFT	ACCOUNTING	(8,134)
CORONADO, SUSAN K.	ACCOUNTING	5,766
RICHARD PEEBLO & ASSOC	ACCOUNTING	3,360
LEONARD MANEWITH	ACCOUNTING	8,311
CARLOS ALCAZAR	ACCOUNTING	2,030
TOTAL ACCOUNTING		25,978

STATE OF ILLINOIS
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V -19 AND VI-A -22 AND XIX-C LEGAL FEES

Type	HR EMPLOYEE	RE TAX ASSESSMENT	COLLECTIONS	FINANCING	WC	Amount
Ash, Anos, Freedman & Logan			124			124
Adelman Gettleman Merens Berish				(362)		(362)
Ashman Law Offices			13,405			13,405
Sharon Dettlo & Baumann et al						-
Law Offices of Jeffrey Albert						-
Law Offices of Segal & Segal	5,652		479			6,131
Schmidt, Saltzman & Moran		18,200				18,200
Jensen Reporting			605			605
Clerk of Court			105			105
NONALLOWABLE			(14,594)			(14,594)
TOTAL	5,652	18,200	124	(362)		23,614